STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155135	A. BUILDING 00 B. WING	01/18/2013

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WESTVIEW NURSING AND REHABILITATION CENTER	1510 CLINIC DR BEDFORD, IN 47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00122128. This visit was inconjuction to the Recertification and State Licensure Survey. Complaint IN00122128 - Substantiated. Federal/state deficiencies related to the allegations are cited at F225 and F226. Survey Dates: January 07, 08, 09, 10, 11, 14, 15, 16, 17, and 18, 2013 Facility number: 000060 Provider number: 155135 AIM number: 100266600 Survey team: Susan Worsham, RN-TC Sharon Whiteman, RN Kimberly Perigo, RN(1/7/13,1/8/13,1/16/13) Census bed type: SNF/NF: 73	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Total: 73 Census payor type: Medicare: 12 Medicaid: 53 Other: 8 Total : 73 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on January 29, 2013; by Kimberly Perigo, RN.			

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview	F0225	**What corrective action(s) will**	02/11/2013

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	the facility failed to ensure nursing staff thoroughly investigated and reported an allegation of neglect to the Administrator and other officials as indicated by their policy and procedures for 1 of 3 residents reviewed for resident care. (Resident #C) Findings Include: During review of the facility's reportable occurrences on 01/16/13 at 11:00 a.m., the following occurrence dated 09/14/12, was noted, "Employee Communication Form....Nurse (Nurse #1) went in this am to help CNA #2 pull resident (Resident #C) up in bed. Nurse observed resident had BM on incontinent pad. Nurse (Nurse #1)was called into room after lunch to see resident sitting in same BM and dirty gown. Nurse had an unassigned CNA change Resident #C at that time.... 2nd (sic)shift reported that multiple people were left unchanged.....Hall trays were left in rooms/insubordinate attitude to charge nurse/shift supervisors....."		**be accomplished for those residents found to have been affected by the deficient practice?** · Resident C did not have a negative outcome related to the alleged deficient practice **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · All allegations of abuse/neglect will be reported to the Administrator/DNS immediately and to the residents representative within 24 hours of report. · All allegations of abuse/neglect will be investigated including interviewing all staff involved, to assure all policies and procedures are followed by the Administrator/DNS. · All abuse/neglect allegations will be reported to the ISDH within 24 hours by the Administrator/DNS. · All staff will be in-serviced on abuse/neglect including what constitutes abuse/neglect, to whom to report abuse and when, his/her responsibility upon witnessing abuse/neglect, by 2/11/13 by the SDC/designee, post test included. Any PRN staff	

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	Written in different handwriting underneath this section was, "On Sat [Saturday] 9-15-12 Nurse (Nurse #1)reports that residents in this CNA's (CNA#2's)section where (sic)not changed and had brown rings under them." This form was check marked at, "Final Written Warning." Interview of the DON [Director of Nursing] on 01/17/13 at 8:16 a.m., indicated the DON had written on the bottom section of the Employee Communication Form what was reported to her by Nurse #1. Interview of Nurse #1 on 01/17/13 at 7:46 a.m., indicated CNA #2 was the CNA assigned to Resident #C on 09/14/12 . Nurse #1 indicated she went in with an unassigned CNA sometime before lunch (but didn't remember the CNA's name) to pull resident #C up in bed and saw that his gown was soiled and had BM on his bed pad. Nurse #1 indicated she had asked CNA #2 to change the resident's bed pad and gown and she (CNA #2)said she would. Nurse #1 indicated this was before lunch.		will be in-serviced prior to their next scheduled shift by the SDC/Designee. · Non-compliance with these procedures will result in further education including disciplinary action. · Administrator/DNS are responsible to ensure compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · All allegations of abuse/neglect will be reported to the Administrator/DNS immediately and to the residents representative within 24 hours of report. · All allegations of abuse/neglect will be investigated including interviewing all staff involved, to assure all policies and procedures are followed by the Administrator/DNS. · All abuse/neglect allegations will be reported to the ISDH within 24 hours by the Administrator/DNS. · All staff will be in-serviced on abuse/neglect including what constitutes abuse/neglect, to whom to report abuse/neglect and when, his/her responsibility upon witnessing abuse/neglect, by 2/11/13 by the SDC/designee, post test included. Any PRN staff will be in-serviced prior to their	

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	Nurse #1 indicated that evening shift had called her in at shift change to report there was still BM on Resident #C's bed pad. Nurse #1 indicated she didn't remember who the evening shift nurse was. Nurse #1 indicated that CNA #2 denied leaving the resident on a soiled pad. Nurse #1 indicated evening shift CNA's had reported to her that they had found sheets soiled with brown rings during bed checks at the start of the evening shift and they had changed the sheets. Nurse #1 indicated she put a note under the DON's door to inform the DON of the allegation. Nurse #1 indicated she did not go to look at the soiled sheets, but she did believe what the CNA's told her. Nurse #1 indicated the CNA's reported they had found brown rings on Resident #C's sheet. . The DON was interviewed on 01/17/13 at 08:16 a.m. The DON indicated the allegation occurred on a Friday and she was not made aware of it until the following Monday. The DON indicated she was made aware of the		next scheduled shift by the SDC/Designee. · Non-compliance with these procedures will result in further education including disciplinary action. · Administrator/DNS are responsible to ensure compliance. **How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The CQI tool for abuse staff interview and abuse prohibition and investigation will be utilized weekly x4, and monthly x6 · Findings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%.	

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	allegations by an "Employee Communication Form." The DON indicated she questioned Nurse #1 and Nurse #1 had reported to her that she didn't see the brown rings but second shift had reported it to her. The DON indicated Nurse #1 had told her (the DON) that the second shift aides had reported dried rings on resident sheets to her (Nurse #1) but they (the evening shift CNAs) had changed the soiled sheets. The DON indicated she didn't remember if she had ask who the evening shift CNA's were who made the allegations and the CNA's were not interviewed. The DON indicated she did discuss the allegations with CNA #2 and she became, "kinda of insubordinate at the time because she felt like she was being picked on." The "Employee Communication Form indicated CNA #2 had refused to sign the form." The DON provided Resident #C's Progress Note dated 09/14/12 at 1:36 p.m., which indicated, "Area to coccyx resolved at this time. Area healed. Scar tissue remains." This Note was signed by the ADON. The Director of Nursing further indicated, the			

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	allegation of neglect had not been reported to the Indiana State Department of Health. A policy titled Abuse Prohibition, Reporting, and Investigation (not dated) was provided by the DON on 01/14/13 at 10:00 a.m. The policy indicated, "It is the policy of American Senior Communities to protect residents from abuse including....neglect....Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the residents. Neglect occurs when a facility fails to provide necessary care for resident, such as situations in which residents are being left to lie in urine or feces....All abuse allegations/abuse must be reported to the Executive Director immediately, and to the resident's representative within 24 hours of the report. Failure to report will result in disciplinary action, up to and including immediate termination.....It is the responsibility of the Administrator/Director of Nursing to report the abuse, or allegations of			

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	abuse, within 24 hours to the Indiana State Department of Health....." This Federal/state tag is relates to Complaint IN00122128. 3.1-28(c) 3.1-28(d)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview the facility failed to ensure implementation of their policy and procedures for 1 of 3 residents reviewed for alleged neglect of resident care. (Resident #C) Findings Include: During review of the facility's reportable occurrences on 01/16/13 at 11:00 a.m., the following occurrence dated 09/14/12, was noted, "Employee Communication Form....Nurse (Nurse #1) went in this am to help CNA #2 pull resident (Resident #C) up in bed. Nurse observed resident had BM on incontinent pad. Nurse (Nurse #1)was called into room after lunch to see resident sitting in same BM and dirty gown. Nurse had an unassigned CNA change Resident #C at that time.... 2nd (sic)shift reported	F0226	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident C did not have a negative outcome related to the alleged deficient practice **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · All allegations of abuse/neglect will be reported to the Administrator/DNS immediately and to the residents representative within 24 hours of report. · All allegations of abuse/neglect will be investigated including interviewing all staff involved, to assure all policies and procedures are followed by the Administrator/DNS. · All abuse/neglect allegations will be reported to the	02/11/2013

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	that multiple people were left unchanged.....Hall trays were left in rooms/insubordinate attitude to charge nurse/shift supervisors....." Written in different handwriting underneath this section was, "On Sat [Saturday] 9-15-12 Nurse (Nurse #1)reports that residents in this CNA's (CNA#2's)section where (sic)not changed and had brown rings under them." This form was check marked at, "Final Written Warning." Interview of the DON [Director of Nursing] on 01/17/13 at 8:16 a.m., indicated the DON had written on the bottom section of the Employee Communication Form what was reported to her by Nurse #1. Interview of Nurse #1 on 01/17/13 at 7:46 a.m., indicated CNA #2 was the CNA assigned to Resident #C on 09/14/12 . Nurse #1 indicated she went in with an unassigned CNA sometime before lunch (but didn't remember the CNA's name) to pull resident #C up in bed and saw that his gown was soiled and had BM on his bed pad. Nurse #1 indicated she		ISDH within 24 hours by the Administrator/DNS. · All staff will be in-serviced on abuse/neglect including what constitutes abuse/neglect, to whom to report abuse and when, his/her responsibility upon witnessing abuse/neglect, by 2/11/13 by the SDC/designee, post test included. Any PRN staff will be in-serviced prior to their next scheduled shift by the SDC/Designee. · Non-compliance with these procedures will result in further education including disciplinary action. · Administrator/DNS are responsible to ensure compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · All allegations of abuse/neglect will be reported to the Administrator/DNS immediately and to the residents representative within 24 hours of report. · All allegations of abuse/neglect will be investigated including interviewing all staff involved, to assure all policies and procedures are followed by the Administrator/DNS. · All abuse/neglect allegations will be reported to the ISDH within 24 hours by the	

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	had asked CNA #2 to change the resident's bed pad and gown and she (CNA #2)said she would. Nurse #1 indicated this was before lunch. Nurse #1 indicated that evening shift had called her in at shift change to report there was still BM on Resident #C's bed pad. Nurse #1 indicated she didn't remember who the evening shift nurse was. Nurse #1 indicated that CNA #2 denied leaving the resident on a soiled pad. Nurse #1 indicated evening shift CNA's had reported to her that they had found sheets soiled with brown rings during bed checks at the start of the evening shift and they had changed the sheets. Nurse #1 indicated she put a note under the DON's door to inform the DON of the allegation. Nurse #1 indicated she did not go to look at the soiled sheets, but she did believe what the CNA's told her. Nurse #1 indicated the CNA's reported they had found brown rings on Resident #C's sheet. . The DON was interviewed on 01/17/13 at 08:16 a.m. The DON indicated the		Administrator/DNS. · All staff will be in-serviced on abuse/neglect including what constitutes abuse/neglect, to whom to report abuse/neglect and when, his/her responsibility upon witnessing abuse/neglect, by 2/11/13 by the SDC/designee, post test included. Any PRN staff will be in-serviced prior to their next scheduled shift by the SDC/Designee. · Non-compliance with these procedures will result in further education including disciplinary action. · Administrator/DNS are responsible to ensure compliance. **How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The CQI tool for abuse staff interview and abuse prohibition and investigation will be utilized weekly x4, and monthly x6 · Findings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%.	

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	allegation occurred on a Friday and she was not made aware of it until the following Monday. The DON indicated she was made aware of the allegations by an "Employee Communication Form." The DON indicated she questioned Nurse #1 and Nurse #1 had reported to her that she didn't see the brown rings but second shift had reported it to her. The DON indicated Nurse #1 had told her (the DON) that the second shift aides had reported dried rings on resident sheets to her (Nurse #1) but they (the evening shift CNAs) had changed the soiled sheets. The DON indicated she didn't remember if she had ask who the evening shift CNA's were who made the allegations and the CNA's were not interviewed. The DON indicated she did discuss the allegations with CNA #2 and she became, "kinda of insubordinate at the time because she felt like she was being picked on." The "Employee Communication Form indicated CNA #2 had refused to sign the form." The DON provided Resident #C's Progress Note dated 09/14/12 at 1:36 p.m., which indicated, "Area to coccyx			

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	resolved at this time. Area healed. Scar tissue remains." This Note was signed by the ADON. The Director of Nursing further indicated, the allegation of neglect had not been reported to the Indiana State Department of Health. A policy titled Abuse Prohibition, Reporting, and Investigation (not dated) was provided by the DON on 01/14/13 at 10:00 a.m. The policy indicated, "It is the policy of American Senior Communities to protect residents from abuse including....neglect....Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the residents. Neglect occurs when a facility fails to provide necessary care for resident, such as situations in which residents are being left to lie in urine or feces....All abuse allegations/abuse must be reported to the Executive Director immediately, and to the resident's representative within 24 hours of the report. Failure to report will result in disciplinary			

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	action, up to and including immediate termination.....It is the responsibility of the Administrator/Director of Nursing to report the abuse, or allegations of abuse, within 24 hours to the Indiana State Department of Health....." This Federal/state tag is relates to Complaint IN00122128. 3.1-28(a)			